Reprinted
April 12, 2001

ENGROSSED
HOUSE BILL No. 1937

DIGEST OF HB 1937 (Updated April 11, 2001 4:17 PM - DI 97)

Citations Affected: IC 27-8; noncode.

Synopsis: ICHIA and health insurance waivers. Specifies that the current 12 month limit for a preexisting condition limitation on an individual policy of accident and sickness insurance applies only if the individual received medical advice, diagnosis, care, or treatment of the condition during the 12 months before the effective date. Provides that an individual or association or discretionary group accident and sickness insurance policy may, if certain conditions are met, contain a waiver of coverage for a specified condition for not more than 5 years. Sets forth guidelines that the Indiana comprehensive health insurance association (ICHIA) must conform to in setting assessments for members. Allows an individual to pay the premium for an ICHIA policy in cash, by bank draft, by check, by cashier's check, by money order, or by credit card, debit card, charge card, or a similar method. Allows the association to contract with a bank or credit card vendor for acceptance of bank cards or credit cards, and that any fees charged for use of the card may be charged to the individual. Authorizes the office of Medicaid policy and planning to apply to the U.S. Department of Health and Human Services for approval of a demonstration waiver to provide coverage to individuals with severe chronic diseases. Requires the health finance advisory committee to review specified issues and make recommendations to the health finance commission not later than May 1, 2002. Requires the commission to make recommendations to the legislative council not later than November 1, 2002.

Effective: Upon passage; July 1, 2001.

Grubb, Smith M

(SENATE SPONSORS — PAUL, MRVAN)

January 17, 2001, read first time and referred to Committee on Insurance, Corporations and Small Business.
February 8, 2001, reported — Do Pass.
February 12, 2001, read second time, ordered engrossed. Engrossed.
February 14, 2001, read third time, passed. Yeas 84, nays 0.

SENATE ACTION

February 27, 2001, read first time and referred to Committee on Insurance and Financial Institutions.
April 5, 2001, amended, reported favorably — Do Pass.
April 11, 2001, read second time, amended, ordered engrossed.

Reprinted
April 12, 2001

First Regular Session 112th General Assembly (2001)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2000 General Assembly.

ENGROSSED
HOUSE BILL No. 1937

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-5-2.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2.5. (a) As used in this section, the term "policy of accident and sickness insurance" does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy issued as an individual policy.

(5) A limited benefit health insurance policy issued as an individual policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

(9) A student health insurance policy.

(b) The benefits provided by an individual policy of accident and sickness insurance may not be excluded, limited, or denied for more than twelve (12) months after the effective date of the coverage because of a preexisting condition of the individual **if the individual received medical advice concerning, diagnosis of, care for, or treatment for the preexisting condition during the twelve (12) month period before the effective date of the coverage.**

(c) An individual policy of accident and sickness insurance may not define a preexisting condition, a rider, or an endorsement more restrictively than as:

(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve (12) months immediately preceding the effective date of enrollment in the plan;

(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve (12) months immediately preceding the effective date of enrollment in the plan; or

(3) a pregnancy existing on the effective date of enrollment in the plan.

(d) An insurer shall reduce the period allowed for a preexisting condition exclusion described in subsection (b) by the amount of time the individual has continuously served under a preexisting condition clause for a policy of accident and sickness insurance issued under IC 27-8-15 if the individual applies for a policy under this chapter not more than thirty (30) days after coverage under a policy of accident and sickness insurance issued under IC 27-8-15 expires.

(e) Notwithstanding subsections (b) and (c), an individual policy of accident and sickness insurance may contain a waiver of coverage for a specified condition and any complications that arise from the specified condition if:

(1) the period for which the exemption would be in effect does not exceed five (5) years; and

(2) all of the following conditions are met:

(A) The insurer provides to the applicant before or at the time of issuance of the policy written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition.

(B) The offer of coverage includes the waiver in a separate section stating in bold print or on a separate form that the

applicant is receiving coverage with an exception for the waived condition.

(C) The offer of coverage does not include more than two (2) waivers per individual.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) Upon written request by the insured, the insurer agrees to review the underwriting basis for the waiver and shall remove the waiver if the evidence of insurability available to the insurer at the time of the review is satisfactory. An insured may not make a request under this section more than once in a twelve (12) month period.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

The insurer shall require an applicant to initial the written notice provided under subdivision (2)(A) and the waiver included in the offer of coverage under subdivision (2)(B) to acknowledge acceptance of the waiver of coverage. An offer of coverage under a policy including a waiver under this subsection does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1(a).

(f) Notwithstanding subsection (e), an individual policy of accident and sickness insurance may not contain a waiver of coverage for a mental health condition.

SECTION 2. IC 27-8-5-19.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 19.2. (a) This section applies to a group policy or certificate of accident and sickness insurance:**

(1) that covers the members of an association or discretionary group; and

(2) under which a certificate of coverage is issued to an individual member of the association or discretionary group.

(b) Notwithstanding section 19 of this chapter, a policy or certificate described in subsection (a) may contain a waiver of coverage for a specified condition and any complications that arise from the specified condition if:

(1) the period for which the waiver would be in effect does not exceed five (5) years; and

(2) all of the following conditions are met:

(A) The insurer provides to the applicant before or at the time of issuance of the policy or certificate written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition.

(B) The offer of coverage includes the waiver in a separate section stating in bold print or on a separate form that the applicant is receiving coverage with an exception for the waived condition.

(C) The offer of coverage does not include more than two (2) waivers per individual.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) Upon written request by the insured, the insurer agrees to review the underwriting basis for the waiver and shall remove the waiver if the evidence of insurability available to the insurer at the time of the review is satisfactory. An insured may not make a request under this section more than once in a twelve (12) month period.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and that any individual to whom the waiver would have applied may apply for a policy or certificate issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(c) The insurer shall require an applicant to initial the written notice provided under subsection (b)(2)(A) and the waiver included in the offer of coverage under subsection (b)(2)(B) to acknowledge acceptance of the waiver of coverage.

(d) An offer of coverage under a policy or certificate including a waiver under this section does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1(a).

(e) Notwithstanding subsection (b), a policy described in subsection (a) may not contain a waiver of coverage for a mental health condition.

SECTION 3. IC 27-8-10-2.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 2.1. (a) There is established a nonprofit legal entity to be referred to as the Indiana comprehensive health insurance association, which must assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the association for coverage. All carriers,

health maintenance organizations, limited service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana must be members of the association. The association shall operate under a plan of operation established and approved under subsection (c) and shall exercise its powers through a board of directors established under this section.

(b) The board of directors of the association consists of seven (7) members whose principal residence is in Indiana selected as follows:

(1) Three (3) members to be appointed by the commissioner from the members of the association, one (1) of which must be a representative of a health maintenance organization.

(2) Two (2) members to be appointed by the commissioner shall be consumers representing policyholders.

(3) Two (2) members shall be the state budget director or designee and the commissioner of the department of insurance or designee.

The commissioner shall appoint the chairman of the board, and the board shall elect a secretary from its membership. The term of office of each appointed member is three (3) years, subject to eligibility for reappointment. Members of the board who are not state employees may be reimbursed from the association's funds for expenses incurred in attending meetings. The board shall meet at least semiannually, with the first meeting to be held not later than May 15 of each year.

(c) The association shall submit to the commissioner a plan of operation for the association and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation becomes effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association and provides for the sharing of association losses on an equitable, proportionate basis among the member carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers. If the association fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules under IC 4-22-2 necessary or advisable to implement this section. These rules are effective until modified by the commissioner or superseded by a plan submitted by the association and approved by

the commissioner. The plan of operation must:

(1) establish procedures for the handling and accounting of assets and money of the association;

(2) establish the amount and method of reimbursing members of the board;

(3) establish regular times and places for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner;

(5) establish procedures whereby selections for the board of directors will be made and submitted to the commissioner for approval;

(6) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and

(7) establish procedures for the periodic advertising of the general availability of the health insurance coverages from the association.

(d) The plan of operation may provide that any of the powers and duties of the association be delegated to a person who will perform functions similar to those of this association. A delegation under this section takes effect only with the approval of both the board of directors and the commissioner. The commissioner may not approve a delegation unless the protections afforded to the insured are substantially equivalent to or greater than those provided under this chapter.

(e) The association has the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (c). The association has the general powers and authority granted under the laws of Indiana to carriers licensed to transact the kinds of health care services or health insurance described in section 1 of this chapter and also has the specific authority to do the following:

(1) Enter into contracts as are necessary or proper to carry out this chapter, subject to the approval of the commissioner.

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.

(3) Take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association.

(4) Establish a medical review committee to determine the

reasonably appropriate level and extent of health care services in each instance.

(5) Establish appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the reasonable operational expenses of the association.

(6) Pool risks among members.

(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by this chapter.

(8) Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.

(9) Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.

(10) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(11) Hire an independent consultant.

(12) Develop a method of advising applicants of the availability of other coverages outside the association and may promulgate a list of health conditions the existence of which would deem an applicant eligible without demonstrating a rejection of coverage by one (1) carrier.

(13) Provide for the use of managed care plans for insureds, including the use of:

(A) health maintenance organizations; and

(B) preferred provider plans.

(14) Solicit bids directly from providers for coverage under this chapter.

(f) Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate scales of premium rates based on age apply for individual risks. Premium rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification may not be more than one hundred fifty percent (150%) of the average premium rate for that class charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year. In determining the average rate of the five

(5) largest carriers, the rates charged by the carriers shall be actuarially adjusted to determine the rate that would have been charged for benefits identical to those issued by the association. All rates adopted by the association must be submitted to the commissioner for approval.

(g) ~~Following the close of the association's fiscal year, the association shall determine the net premiums, the expenses of administration, and the incurred losses for the year. Any net loss~~ **Assessments made to members of the association in accordance with subdivision (1)** shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums, excluding premiums for Medicaid contracts with the state of Indiana, received in Indiana ~~during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association or any other equitable basis as may be provided in the plan of operation.~~ **for the immediate past calendar year.** For self-insurers, health maintenance organizations, and limited service health maintenance organizations that are members of the association, the proportionate share of losses must be determined through the application of an equitable formula based upon claims paid, excluding claims for Medicaid contracts with the state of Indiana, or the value of services provided. In sharing losses, the association may abate or defer in any part the assessment of a member, if, in the opinion of the ~~board,~~ **commissioner,** payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for interim assessments against members of the association if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the association's ~~next~~ fiscal year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums. Assessments must be determined by the board members specified in subsection (b)(1), subject to final approval by the commissioner. **The association shall conform to the following in carrying out this subsection:**

(1) Before October 1 of each year, the board shall adopt a budget of operations that shall include funds necessary for the payment of the following:

(A) Claims.

(B) Administrative expenses.

(C) Reserves.

(D) Working capital.

(E) Interest expenses.

Each member of the association shall be notified by November

15 of each year of the member's estimated annual assessment for funding the budget for the following year. The actual assessment may be less than but may not exceed the estimated assessment.

(2) If a member's semiannual assessment under this chapter is more than fifty thousand dollars ($50,000), the board may allow the member to pay the assessment in six (6) monthly installments.

(3) The board may borrow funds from a financial institution or from the state in order to provide working capital for the operation of the association.

(4) The board may assess a penalty of at most one percent (1%) per month for any late payment of an assessment unless the assessment is determined by the commissioner to be exempt from the penalty.

(5) By July 31 of each year, a member shall provide the association with a certified independent audit report that shows the amount of tax credits against the assessments as provided by subsection (n) that the member has taken during the previous calendar year.

(h) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association, and the association shall have an annual audit of its operations by an independent certified public accountant.

(i) The association is subject to examination by the department of insurance under IC 27-1-3.1. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(j) All policy forms issued by the association must conform in substance to prototype forms developed by the association, must in all other respects conform to the requirements of this chapter, and must be filed with and approved by the commissioner before their use.

(k) The association may not issue an association policy to any individual who, on the effective date of the coverage applied for, does not meet the eligibility requirements of section 5.1 of this chapter.

(l) The association shall pay an agent's referral fee of twenty-five dollars ($25) to each insurance agent who refers an applicant to the association if that applicant is accepted.

(m) The association and the premium collected by the association shall be exempt from the premium tax, the gross income tax, the adjusted gross income tax, supplemental corporate net income, or any combination of these, or similar taxes upon revenues or income that

may be imposed by the state.

(n) Members who after July 1, 1983, during any calendar year, have paid one (1) or more assessments levied under this chapter may either:

(1) take a credit against premium taxes, gross income taxes, adjusted gross income taxes, supplemental corporate net income taxes, or any combination of these, or similar taxes upon revenues or income of member insurers that may be imposed by the state, up to the amount of the taxes due for each calendar year in which the assessments were paid and for succeeding years until the aggregate of those assessments have been offset by either credits against those taxes or refunds from the association; or

(2) any member insurer may include in the rates for premiums charged for insurance policies to which this chapter applies amounts sufficient to recoup a sum equal to the amounts paid to the association by the member less any amounts returned to the member insurer by the association, and the rates shall not be deemed excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the member.

(o) The association shall provide for the option of monthly collection of premiums.

SECTION 4. IC 27-8-10-5.1, AS AMENDED BY P.L.233-1999, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5.1. (a) Except as provided in subsections (b) and (c), a person is not eligible for an association policy if, at the effective date of coverage, the person has or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. **However, an offer of coverage described in IC 27-8-5-2.5(e) or IC 27-8-5-19.2(b) does not affect an individual's eligibility for an association policy under this subsection.** Coverage under any association policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(b) Except as provided in IC 27-13-16-4, a person is eligible for an association policy upon a showing that:

(1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restrictions;

(2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; or

(3) the person is a federally eligible individual.

For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of age from eligibility for an association policy.

(c) The board of directors may establish procedures that would permit:

(1) an association policy to be issued to persons who are covered by a group insurance arrangement when that person or a dependent's health condition is such that the group's coverage is in jeopardy of termination or material rate increases because of that person's or dependent's medical claims experience; and

(2) an association policy to be issued without any limitation on preexisting conditions to a person who is covered by a health insurance arrangement when that person's coverage is scheduled to terminate for any reason beyond the person's control.

(d) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full-time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried child's coverage while the dependent is and continues to be both:

(1) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

(2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(e) An association policy that provides coverage for a family member of the person in whose name the contract is issued must, as to the family member's coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the

coverage continued beyond the thirty-one (31) day period.

(f) Except as provided in subsection (g), an association policy may contain provisions under which coverage is excluded during a period of three (3) months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of three (3) months before the effective date of coverage. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(g) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (b), then an association policy may not contain provisions under which:

(1) coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or

(2) coverage as to a given condition is denied;

on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(h) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.

SECTION 5. IC 27-8-10-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 11. (a) An individual may pay a premium for an association policy:**

(1) in cash;

(2) by bank draft;

(3) by check;

(4) by cashier's check;

(5) by money order; or

(6) by credit card, debit card, charge card, or a similar method.

However, if a premium payment is made by bank draft, check, cashier's check, or money order, the liability is not finally discharged and the individual has not paid the premium until the draft, check, or money order has been honored by the institution on which it is drawn. If the payment is made by credit card, debit card, charge card, or similar method, the liability is not finally discharged and the individual has not paid the premium until the association receives payment or credit from the institution

responsible for making the payment or credit.

(b) The association may contract with a bank or credit card vendor for acceptance of bank or credit cards. However, if there is a vendor transaction charge or discount fee, whether billed to the association or charged directly to the association's account, the association or credit card vendor may collect from the individual using the bank or credit card a fee that may not exceed the highest transaction charge or discount fee charged to the association by the bank or credit card vendor during the most recent collection period. This fee may be collected regardless of any agreement between the bank and a credit card vendor or regardless of any internal policy of the credit card vendor that may prohibit this type of fee. The fee is a permitted additional charge under IC 24-4.5-3-202.

(c) The association shall issue a receipt for a premium payment that is made with currency.

SECTION 6. [EFFECTIVE JULY 1, 2001] **(a) As used in this SECTION, "waiver" refers to a Section 1115 demonstration waiver under the federal Social Security Act (42 U.S.C. 1315).**

(b) The office of Medicaid policy and planning may apply to the United States Department of Health and Human Services for approval of a waiver to provide coverage to individuals with severe chronic diseases.

(c) If a provision of this SECTION differs from the requirements of a waiver, the office of Medicaid policy and planning shall submit the waiver request in a manner that complies with the requirements of the waiver. However, if the waiver is approved, the office shall apply not more than one hundred twenty (120) days after the waiver is approved for an amendment to the approved waiver that contains the provisions under this SECTION that were not included in the approved waiver.

(d) The office of Medicaid policy and planning may not implement a waiver until the office files an affidavit with the governor attesting that a federal waiver applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not more than five (5) days after the office is notified that a waiver is approved.

(e) If the office of Medicaid policy and planning receives a waiver under this SECTION from the United States Department of Health and Human Services and the governor receives the affidavit filed under subsection (d), the office shall implement the waiver not more than sixty (60) days after the governor receives

the affidavit.

(f) The office of Medicaid policy and planning may adopt rules under IC 4-22-2 necessary to implement this SECTION.

(g) This SECTION expires July 1, 2004.

SECTION 7. [EFFECTIVE JULY 1, 2001] **(a) As used in this SECTION, "association" refers to the Indiana comprehensive health insurance association established by IC 27-8-10-2.1.**

(b) As used in this SECTION, "association policy" has the meaning set forth in IC 27-8-10-1.

(c) As used in this SECTION, "commission" refers to the health finance commission established under IC 2-5-23.

(d) The health finance advisory committee established by IC 2-5-23-6 shall review the following issues and make recommendations to the commission not later than May 1, 2002:

(1) The current program used by the association to provide coverage for health care services provided to individuals who are covered under an association policy.

(2) The potential sources of funding coverage of association policies and administrative expenses.

(3) Current criteria for determining eligibility and methodology for establishing premiums.

(4) A plan for administration of the association program by an existing state agency with review by the commission or another legislative body.

(5) The potential transfer of individuals who are covered under an association policy to private insurance coverage.

(6) Whether the association should be terminated and replaced by another health care program.

(e) The commission shall make recommendations concerning the issues specified in subsection (d) to the legislative council not later than November 1, 2002.

(f) This SECTION expires June 30, 2003.

SECTION 8. [EFFECTIVE UPON PASSAGE] **IC 27-8-5-2.5, as amended by this act, and IC 27-8-5-19.2, as added by this act, apply to a policy of accident and sickness insurance that is issued or delivered after the effective date of this act.**

SECTION 9. **An emergency is declared for this act.**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred House Bill 1937, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill do pass.

CROOKS, Chair

Committee Vote: yeas 11, nays 0.

COMMITTEE REPORT

Mr. President: The Senate Committee on Insurance and Financial Institutions, to which was referred House Bill No. 1937, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 27-8-10-2.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 2.1. (a) There is established a nonprofit legal entity to be referred to as the Indiana comprehensive health insurance association, which must assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the association for coverage. All carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana must be members of the association. The association shall operate under a plan of operation established and approved under subsection (c) and shall exercise its powers through a board of directors established under this section.

(b) The board of directors of the association consists of seven (7) members whose principal residence is in Indiana selected as follows:

(1) Three (3) members to be appointed by the commissioner from the members of the association, one (1) of which must be a representative of a health maintenance organization.

(2) Two (2) members to be appointed by the commissioner shall be consumers representing policyholders.

(3) Two (2) members shall be the state budget director or designee and the commissioner of the department of insurance or designee.

The commissioner shall appoint the chairman of the board, and the board shall elect a secretary from its membership. The term of office of each appointed member is three (3) years, subject to eligibility for reappointment. Members of the board who are not state employees may be reimbursed from the association's funds for expenses incurred in attending meetings. The board shall meet at least semiannually, with the first meeting to be held not later than May 15 of each year.

(c) The association shall submit to the commissioner a plan of operation for the association and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation becomes effective upon approval in writing by the commissioner consistent with the date on

which the coverage under this chapter must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association and provides for the sharing of association losses on an equitable, proportionate basis among the member carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers. If the association fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules under IC 4-22-2 necessary or advisable to implement this section. These rules are effective until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. The plan of operation must:

(1) establish procedures for the handling and accounting of assets and money of the association;

(2) establish the amount and method of reimbursing members of the board;

(3) establish regular times and places for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner;

(5) establish procedures whereby selections for the board of directors will be made and submitted to the commissioner for approval;

(6) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and

(7) establish procedures for the periodic advertising of the general availability of the health insurance coverages from the association.

(d) The plan of operation may provide that any of the powers and duties of the association be delegated to a person who will perform functions similar to those of this association. A delegation under this section takes effect only with the approval of both the board of directors and the commissioner. The commissioner may not approve a delegation unless the protections afforded to the insured are substantially equivalent to or greater than those provided under this chapter.

(e) The association has the general powers and authority enumerated by this subsection in accordance with the plan of operation approved

by the commissioner under subsection (c). The association has the general powers and authority granted under the laws of Indiana to carriers licensed to transact the kinds of health care services or health insurance described in section 1 of this chapter and also has the specific authority to do the following:

(1) Enter into contracts as are necessary or proper to carry out this chapter, subject to the approval of the commissioner.

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.

(3) Take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association.

(4) Establish a medical review committee to determine the reasonably appropriate level and extent of health care services in each instance.

(5) Establish appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the reasonable operational expenses of the association.

(6) Pool risks among members.

(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by this chapter.

(8) Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.

(9) Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.

(10) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(11) Hire an independent consultant.

(12) Develop a method of advising applicants of the availability of other coverages outside the association and may promulgate a list of health conditions the existence of which would deem an applicant eligible without demonstrating a rejection of coverage by one (1) carrier.

(13) Provide for the use of managed care plans for insureds, including the use of:

(A) health maintenance organizations; and

(B) preferred provider plans.

(14) Solicit bids directly from providers for coverage under this chapter.

(f) Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate scales of premium rates based on age apply for individual risks. Premium rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification may not be more than one hundred fifty percent (150%) of the average premium rate for that class charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year. In determining the average rate of the five (5) largest carriers, the rates charged by the carriers shall be actuarially adjusted to determine the rate that would have been charged for benefits identical to those issued by the association. All rates adopted by the association must be submitted to the commissioner for approval.

(g) ~~Following the close of the association's fiscal year, the association shall determine the net premiums, the expenses of administration, and the incurred losses for the year. Any net loss~~ **Assessments made to members of the association in accordance with subdivision (1)** shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums, excluding premiums for Medicaid contracts with the state of Indiana, received in Indiana ~~during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association or any other equitable basis as may be provided in the plan of operation.~~ **for the immediate past calendar year.** For self-insurers, health maintenance organizations, and limited service health maintenance organizations that are members of the association, the proportionate share of losses must be determined through the application of an equitable formula based upon claims paid, excluding claims for Medicaid contracts with the state of Indiana, or the value of services provided. In sharing losses, the association may abate or defer in any part the assessment of a member, if, in the opinion of the ~~board,~~ **commissioner,** payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for interim assessments against members of the association if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the association's ~~next~~ fiscal

year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums. Assessments must be determined by the board members specified in subsection (b)(1), subject to final approval by the commissioner. **The association shall conform to the following in carrying out this subsection:**

(1) Before October 1 of each year, the board shall adopt a budget of operations that shall include funds necessary for the payment of the following:

(A) Claims.

(B) Administrative expenses.

(C) Reserves.

(D) Working capital.

(E) Interest expenses.

Each member of the association shall be notified by November 15 of each year of the member's estimated annual assessment for funding the budget for the following year. The actual assessment may be less than but may not exceed the estimated assessment.

(2) If a member's semiannual assessment under this chapter is more than fifty thousand dollars ($50,000), the board may allow the member to pay the assessment in six (6) monthly installments.

(3) The board may borrow funds from a financial institution or from the state in order to provide working capital for the operation of the association.

(4) The board may assess a penalty of at most one percent (1%) per month for any late payment of an assessment unless the assessment is determined by the commissioner to be exempt from the penalty.

(5) By July 31 of each year, a member shall provide the association with a certified independent audit report that shows the amount of tax credits against the assessments as provided by subsection (n) that the member has taken during the previous calendar year.

(h) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association, and the association shall have an annual audit of its operations by an independent certified public accountant.

(i) The association is subject to examination by the department of insurance under IC 27-1-3.1. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(j) All policy forms issued by the association must conform in substance to prototype forms developed by the association, must in all other respects conform to the requirements of this chapter, and must be filed with and approved by the commissioner before their use.

(k) The association may not issue an association policy to any individual who, on the effective date of the coverage applied for, does not meet the eligibility requirements of section 5.1 of this chapter.

(l) The association shall pay an agent's referral fee of twenty-five dollars ($25) to each insurance agent who refers an applicant to the association if that applicant is accepted.

(m) The association and the premium collected by the association shall be exempt from the premium tax, the gross income tax, the adjusted gross income tax, supplemental corporate net income, or any combination of these, or similar taxes upon revenues or income that may be imposed by the state.

(n) Members who after July 1, 1983, during any calendar year, have paid one (1) or more assessments levied under this chapter may either:

(1) take a credit against premium taxes, gross income taxes, adjusted gross income taxes, supplemental corporate net income taxes, or any combination of these, or similar taxes upon revenues or income of member insurers that may be imposed by the state, up to the amount of the taxes due for each calendar year in which the assessments were paid and for succeeding years until the aggregate of those assessments have been offset by either credits against those taxes or refunds from the association; or

(2) any member insurer may include in the rates for premiums charged for insurance policies to which this chapter applies amounts sufficient to recoup a sum equal to the amounts paid to the association by the member less any amounts returned to the member insurer by the association, and the rates shall not be deemed excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the member.

(o) The association shall provide for the option of monthly collection of premiums.".

Page 2, after line 18, begin a new paragraph and insert:

"SECTION 3. [EFFECTIVE JULY 1, 2001] **(a) As used in this SECTION, "waiver" refers to a Section 1115 demonstration waiver under the federal Social Security Act (42 U.S.C. 1315).**

(b) The office of Medicaid policy and planning may apply to the United States Department of Health and Human Services for approval of a waiver to provide coverage to individuals with severe chronic diseases.

(c) If a provision of this SECTION differs from the requirements of a waiver, the office of Medicaid policy and planning shall submit the waiver request in a manner that complies with the requirements of the waiver. However, if the waiver is approved, the office shall apply not more than one hundred twenty (120) days after the waiver is approved for an amendment to the approved waiver that contains the provisions under this SECTION that were not included in the approved waiver.

(d) The office of Medicaid policy and planning may not implement a waiver until the office files an affidavit with the governor attesting that a federal waiver applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not more than five (5) days after the office is notified that a waiver is approved.

(e) If the office of Medicaid policy and planning receives a waiver under this SECTION from the United States Department of Health and Human Services and the governor receives the affidavit filed under subsection (d), the office shall implement the waiver not more than sixty (60) days after the governor receives the affidavit.

(f) The office of Medicaid policy and planning may adopt rules under IC 4-22-2 necessary to implement this SECTION.

(g) This SECTION expires July 1, 2004.

SECTION 4. [EFFECTIVE JULY 1, 2001] **(a) As used in this SECTION, "association" refers to the Indiana comprehensive health insurance association established by IC 27-8-10-2.1.**

(b) As used in this SECTION, "association policy" has the meaning set forth in IC 27-8-10-1.

(c) As used in this SECTION, "commission" refers to the health finance commission established under IC 2-5-23.

(d) The health finance advisory committee established by IC 2-5-23-6 shall review the following issues and make recommendations to the commission not later than May 1, 2002:

(1) The current program used by the association to provide coverage for health care services provided to individuals who are covered under an association policy.

(2) The potential sources of funding coverage of association policies and administrative expenses.

(3) Current criteria for determining eligibility and methodology for establishing premiums.

(4) A plan for administration of the association program by an existing state agency with review by the commission or

another legislative body.

(5) The potential transfer of individuals who are covered under an association policy to private insurance coverage.

(6) Whether the association should be terminated and replaced by another health care program.

(e) The commission shall make recommendations concerning the issues specified in subsection (d) to the legislative council not later than November 1, 2002.

(f) This SECTION expires June 30, 2003.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1937 as printed February 9, 2001.)

PAUL, Chairperson

Committee Vote: Yeas 9, Nays 0.

SENATE MOTION

Mr. President: I move that Engrossed House Bill 1937 be amended to read as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 27-8-5-2.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2.5. (a) As used in this section, the term "policy of accident and sickness insurance" does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy issued as an individual policy.

(5) A limited benefit health insurance policy issued as an individual policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

(9) A student health insurance policy.

(b) The benefits provided by an individual policy of accident and sickness insurance may not be excluded, limited, or denied for more than twelve (12) months after the effective date of the coverage because of a preexisting condition of the individual **if the individual received medical advice concerning, diagnosis of, care for, or treatment for the preexisting condition during the twelve (12) month period before the effective date of the coverage.**

(c) An individual policy of accident and sickness insurance may not define a preexisting condition, a rider, or an endorsement more restrictively than as:

(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve (12) months immediately preceding the effective date of enrollment in the plan;

(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve (12) months immediately preceding the effective date of enrollment in the plan; or

(3) a pregnancy existing on the effective date of enrollment in the plan.

(d) An insurer shall reduce the period allowed for a preexisting condition exclusion described in subsection (b) by the amount of time the individual has continuously served under a preexisting condition clause for a policy of accident and sickness insurance issued under IC 27-8-15 if the individual applies for a policy under this chapter not more than thirty (30) days after coverage under a policy of accident and sickness insurance issued under IC 27-8-15 expires.

(e) Notwithstanding subsections (b) and (c), an individual policy of accident and sickness insurance may contain a waiver of coverage for a specified condition and any complications that arise from the specified condition if:

(1) the period for which the exemption would be in effect does not exceed five (5) years; and

(2) all of the following conditions are met:

(A) The insurer provides to the applicant before or at the time of issuance of the policy written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition.

(B) The offer of coverage includes the waiver in a separate section stating in bold print or on a separate form that the applicant is receiving coverage with an exception for the waived condition.

(C) The offer of coverage does not include more than two (2) waivers per individual.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) Upon written request by the insured, the insurer agrees to review the underwriting basis for the waiver and shall remove the waiver if the evidence of insurability available to the insurer at the time of the review is satisfactory. An insured may not make a request under this section more than once in a twelve (12) month period.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

The insurer shall require an applicant to initial the written notice provided under subdivision (2)(A) and the waiver included in the offer of coverage under subdivision (2)(B) to acknowledge

acceptance of the waiver of coverage. An offer of coverage under a policy including a waiver under this subsection does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1(a).

(f) Notwithstanding subsection (e), an individual policy of accident and sickness insurance may not contain a waiver of coverage for a mental health condition.

SECTION 2. IC 27-8-5-19.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 19.2. (a) This section applies to a group policy or certificate of accident and sickness insurance:**

(1) that covers the members of an association or discretionary group; and

(2) under which a certificate of coverage is issued to an individual member of the association or discretionary group.

(b) Notwithstanding section 19 of this chapter, a policy or certificate described in subsection (a) may contain a waiver of coverage for a specified condition and any complications that arise from the specified condition if:

(1) the period for which the waiver would be in effect does not exceed five (5) years; and

(2) all of the following conditions are met:

(A) The insurer provides to the applicant before or at the time of issuance of the policy or certificate written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition.

(B) The offer of coverage includes the waiver in a separate section stating in bold print or on a separate form that the applicant is receiving coverage with an exception for the waived condition.

(C) The offer of coverage does not include more than two (2) waivers per individual.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) Upon written request by the insured, the insurer agrees to review the underwriting basis for the waiver and shall remove the waiver if the evidence of insurability available to the insurer at the time of the review is satisfactory. An insured may not make a request under this section more than once in a twelve (12) month period.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and that any individual to whom the waiver would have applied may apply for a policy or certificate issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(c) The insurer shall require an applicant to initial the written notice provided under subsection (b)(2)(A) and the waiver included in the offer of coverage under subsection (b)(2)(B) to acknowledge acceptance of the waiver of coverage.

(d) An offer of coverage under a policy or certificate including a waiver under this section does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1(a).

(e) Notwithstanding subsection (b), a policy described in subsection (a) may not contain a waiver of coverage for a mental health condition.".

Page 7, between lines 9 and 10, begin a new paragraph and insert:

"SECTION 4. IC 27-8-10-5.1, AS AMENDED BY P.L.233-1999, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5.1. (a) Except as provided in subsections (b) and (c), a person is not eligible for an association policy if, at the effective date of coverage, the person has or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. **However, an offer of coverage described in IC 27-8-5-2.5(e) or IC 27-8-5-19.2(b) does not affect an individual's eligibility for an association policy under this subsection.** Coverage under any association policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(b) Except as provided in IC 27-13-16-4, a person is eligible for an association policy upon a showing that:

(1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restrictions;

(2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; or

(3) the person is a federally eligible individual.

For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of age from eligibility for an association policy.

(c) The board of directors may establish procedures that would permit:

(1) an association policy to be issued to persons who are covered by a group insurance arrangement when that person or a dependent's health condition is such that the group's coverage is in jeopardy of termination or material rate increases because of that person's or dependent's medical claims experience; and

(2) an association policy to be issued without any limitation on preexisting conditions to a person who is covered by a health insurance arrangement when that person's coverage is scheduled to terminate for any reason beyond the person's control.

(d) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full-time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried child's coverage while the dependent is and continues to be both:

(1) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

(2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(e) An association policy that provides coverage for a family member of the person in whose name the contract is issued must, as to the family member's coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the coverage continued beyond the thirty-one (31) day period.

(f) Except as provided in subsection (g), an association policy may contain provisions under which coverage is excluded during a period

of three (3) months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of three (3) months before the effective date of coverage. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(g) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (b), then an association policy may not contain provisions under which:

(1) coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or

(2) coverage as to a given condition is denied;

on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(h) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.".

Page 9, after line 18, begin a new paragraph and insert:

"SECTION 8. [EFFECTIVE UPON PASSAGE] **IC 27-8-5-2.5, as amended by this act, and IC 27-8-5-19.2, as added by this act, apply to a policy of accident and sickness insurance that is issued or delivered after the effective date of this act.**

SECTION 9. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

(Reference is to EHB 1937 as printed April 6, 2001.)

NUGENT